Temporary Employee Benefits Guide

Benefits Eligible Assignments

2010

City of Seattle
for health and living — take charge

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Please note: We've made every attempt to ensure the accuracy of this information. If there is any discrepancy between this booklet, the insurance contracts, other legal documents or the terms of an authorized collective bargaining agreement, the contracts, legal documents and applicable collective bargaining agreements will always govern. The City of Seattle intends to continue these plans indefinitely but reserves the right to amend or terminate them at anytime in whole or part, for any reason, according to the amendment and termination procedures described in the legal documents. This booklet does not create a contract of employment with the City of Seattle.

Helping You Make Informed Decisions

For more information about benefits at the City of Seattle, visit the City's Intranet site at http://inweb/personnel/benefits

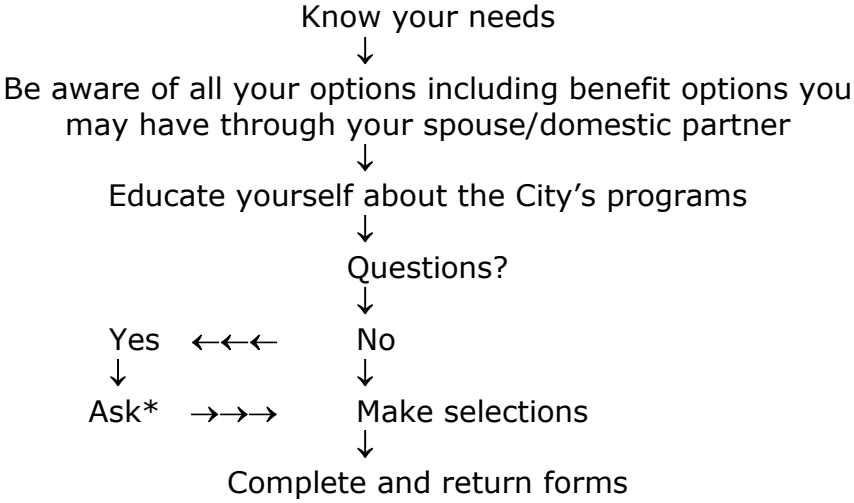
This publication will give you the information you need to help you make benefit program decisions. As you read through the booklet, keep in mind your needs and the needs of your family and use this information to help you decide which programs will best serve those needs.

Remember that you have 31 days from the date you are notified of your eligibility for benefits to submit your benefit enrollment forms.

This booklet will help you to:

- Understand your benefit choices offered by the City of Seattle.
- Select the benefit options that best fit the needs of you and your family.
- Know which forms must be completed and submitted for enrollment.
- Know where to get additional benefits information.

Here are the steps to follow when making your selections:



*Call your department Human Resources representative or the City's Benefits Unit (206-615-1340) if you have questions.

Helping You Make Informed Decisions

When do I enroll?	You must submit your benefits enrollment forms within 31 days of eligibility.
What if I miss the enrollment deadline?	If you fail to submit your enrollment forms within 31 days, you will not be able to enroll in a medical plan until the next open enrollment period (or within 31 days of a change in family status). However, you will automatically be enrolled for dental and vision coverage. Your dental coverage will default to the Washington Dental Services plan. You will also need to meet additional requirements to be eligible for Life Insurance and Long-Term Disability Insurance (LTD). You will be required to submit a Medical History Statement and have it approved by the insurance company in order to be eligible for Life Insurance coverage. You will have an additional waiting period for LTD.
How do I enroll?	To enroll in medical, dental and vision coverage, you must complete and submit a benefit election form to your Human Resources Representative. Optional insurances have separate enrollment forms. Make sure all forms are signed and dated before they are submitted. Forms are available at the end of this booklet, from your Human Resources Representative or on the Personnel Department's Benefits website at http://personnelweb/benefits.
When does my coverage begin?	Coverage begins for you and your dependents on the first day of the month following the date your assignment became benefit eligible. To be covered, you must submit a completed benefits enrollment form to your Benefit Representative within 31 days of eligibility. You may decline coverage, but will not be eligible for premium pay in lieu of benefits as a result of declining coverage.
Continuing Eligibility	To remain eligible for City paid benefits, you must have at least 80 hours of paid time during the calendar month. If the number of hours worked per month is less than 80 hours, benefits will be terminated retroactively and you will be responsible for any charges incurred.

Helping You Make Informed Decisions

Covering Your Dependents

The following dependents are eligible for coverage:

- Your spouse or domestic partner (an Affidavit of Marriage/Domestic Partnership must be filed with your Department's Human Resources Unit)
- Your children, and your spouse's or domestic partner's children who are under age 25, unmarried, living with you, and primarily dependent on you for support regardless of whether they are in school.
- Coverage may continue for a handicapped/incapacitated child if the child becomes disabled prior to the limiting age, provided that proof of his or her fully handicapped/incapacitated status has been documented by a physician.

Enrollment Deadlines

You must enroll a new spouse or domestic partner within 31 days of your marriage or establishment of a domestic partnership. You have 60 days to add a child acquired through birth, adoption, placement for adoption, legal guardianship, marriage or domestic partnership. If you miss the deadline, you can only add dependents during the annual open enrollment period unless you have a change in family status.

Change in Family Status

Federal law defines a change in family status as:

- Birth, adoption, placement of a child, or legal guardianship;
- Retirement or termination of employment;
- Reduction in hours;
- Unpaid leave of absence;
- Termination of Family and Medical Leave;
- Loss of a child's, spouse's, or domestic partner's eligibility under another health plan;
- Marriage or formation of a domestic partnership;
- Divorce or termination of a domestic partnership; or
- Spouse/partner gaining employment with health benefits.

Health Care Options	
Medical Plans	City of Seattle Preventive Plan City of Seattle Traditional Plan Group Health Standard Plan Group Health Deductible Plan
Dental Plans	Washington Dental Service (WDS) Dental Health Services
Vision Plan	Vision Service Plan
Other Insurance	Long-Term Disability Basic Life Insurance
	Remember - You have 31 days from your notice of eligibility date to enroll in the medical, dental, vision and optional insurance plans.

Health Care Options

How to Choose a Medical Plan

The City offers four different medical plans. Plan features, coverages and costs vary. The City's self-insured plans offer unlimited choice of doctors; however, coverage is better if you use doctors in the Aetna network. The Group Health Cooperative (GHC) plans require that you use the GHC network of doctors, clinics, hospitals and pharmacies, but offer a higher level of coverage. Plans offering better coverage (City Preventive and Group Health Standard) have lower copays but higher monthly premiums. Plans with larger annual deductibles have lower or no monthly premiums.

When making your decisions, you should consider cost, choice, and coverage. Here are some questions to ask yourself:

- Do you want a plan that allows you to choose any doctor, hospital or clinic (City self-insured plans) or are you willing to stay within a network (GHC) and receive a higher level of coverage?
- Would you rather pay higher monthly premiums to have a small annual deductible (City Preventive Plan) or no annual deductible (GHC Standard Plan) and smaller copays?
- Would you rather pay lower or no monthly premiums and have higher coinsurance and deductibles (GHC Deductible and City Traditional plans)?

The following very brief plan descriptions may help you make these choices.

Health Care Options	
City of Seattle Self-insured Plans	The City has two self-insured plans — the Preventive Plan and the Traditional Plan. The plans use the Aetna network of providers, and Aetna administers the claims.
Preventive Plan	This plan has a $100 annual deductible per person ($300 per family) and a $15 copay for all office visits except preventive care (which is covered at 100%). The deductible applies to most services except where a copay applies. Most other services are covered at 90% after a copay if you use an Aetna network provider.
Traditional Plan	This plan has a $400 annual deductible per person ($1,200 per family). Most services are covered at 80% if you use an Aetna network provider. Most preventive care is not covered.
What If Don't Use the Aetna Network?	Both of the City's self-insured plans include the Aetna network of doctors; however, you choose whether to use a network or non-network provider when you require care. If you choose a doctor who is not in the network, you will pay a higher percentage of the cost of the visit. Another issue to keep in mind is that prices charged by a non-network provider are often higher than those charged by a network provider. If you use a non-network provider, you will pay 40% of the network cost for a service, and your doctor may charge you the entire amount over the established network price.
Aetna's Aexcel Network	Aetna has a special sub-network, called the Aexcel network, which consists of doctors who specialize in the following areas: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/ gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, vascular surgery and urology. Doctors were selected for this special network because they meet screening criteria in the areas of experience, performance, effectiveness and efficiency. If you need care in one of these areas and you **do not** choose a doctor from the Aexcel network to provide that care, you will pay 10% higher coinsurance. You do not need a referral to see a specialist.

Health Care Options

Group Health Cooperative	Group Health Cooperative (GHC) is a health maintenance organization which provides an integrated system of health care services. All services are delivered in GHC clinics, hospitals and pharmacies. You must use GHC providers and facilities unless a GHC doctor refers you elsewhere. You do not need a physician's referral to see most GHC specialists. The City offers two plans through Group Health Cooperative.
Group Health Standard Plan	This is a managed care plan with no deductible and an office copay of $15. Most services are covered at 100% after payment of a copay. Preventive care is covered.
Group Health Deductible Plan	This is a managed care plan with a $200 annual deductible per person ($600 per family) and an office copay of $15. The deductible does not apply to ambulance service, prescription drugs, durable medical equipment and preventive visits (preventive visits do have a copay). After the deductible is satisfied, most services are covered at 100% after payment of a copay.

Health Care Options

2010 Premiums

Effective January 1, 2010, you will pay the monthly premium amount listed below for the medical plan you select. The table also shows what the City pays each month for each employee's coverage.

Medical Plan	Employee's Monthly Premium (with or without children)	City's Contribution toward Total Premium	Total Monthly Premium
City of Seattle Preventive	$48.12	$851.58	$899.70
City of Seattle Traditional	$ 0.00	$813.11	$813.11
GHC Standard	$48.40	$818.60	$867.33
GHC Deductible	$25.00	$773.63	$798.63

Medical Plan	Employee's Monthly Premium with Spouse/Partner (with or without children)	City's Contribution toward Total Premium	Total Monthly Premium
City of Seattle Preventive	$98.50	$801.20	$899.70
City of Seattle Traditional	$32.34	$780.77	$813.11
GHC Standard	$99.90	$767.43	$867.33
GHC Deductible	$56.92	$741.71	$798.63

Your premium will be divided into two equal payments and taken from the first two pay checks of the month before the actual month of coverage. (Deductions taken in January will pay the February premium.) No premiums are deducted from the third paycheck. Premiums are deducted on a pre-tax basis, which will save you 15%-30% on taxes, depending on your tax bracket.

Value of Benefits May Be Taxable

To cover a spouse or domestic partner (and dependents of your domestic partner), you must complete a Benefit Election form and an Affidavit of Marriage/ Domestic Partnership. If you enroll your domestic partner and your domestic partner's children, you will be taxed on the value of their medical coverage if they are not your tax dependents. (The value of the benefits will be added to your gross income.) The table below shows the taxable values for benefits for domestic partner and dependents.

Termination of a Domestic Partner

Employees may terminate a domestic partner's coverage any time during the year by completing a Benefit Election Form removing the individual from coverage. When an employee terminates a domestic partner from coverage due to a termination of the partnership, a Statement of Termination of Marriage/ Domestic Partnership form also must be completed. An employee cannot file a new Affidavit until 90 days have elapsed from the termination of the prior partnership, unless the termination was due to the domestic partner's death.

After Tax Premium Contribution for Same-Sex Spouse/ Domestic Partner

If you choose to cover a domestic partner or same-sex spouse **who is <u>not</u> your IRS tax dependent**, the portion of the premium deducted from your paycheck (your contribution) that pays for his/her coverage must be taken "after tax" to comply with IRS regulations. The column headed "**Amount of Premium Taken After Taxes**" shows the portion of your monthly premium contribution that will be deducted from your paycheck after taxes are paid.

Medical Plans	Monthly Premium Contribution Taken After-Taxes for Domestic Partner/Same-Sex Spouse
City of Seattle Preventive	$50.38
City of Seattle Traditional	$32.34
GHC Standard	$51.50
GHC Deductible	$31.92

If your domestic partner/same-sex spouse, your age 19-24 year old children and/or your partner's non-IRS tax dependent's children do not qualify as your IRS tax dependents, you will also be taxed on the City-paid **value** of their medical, dental and vision coverage as required by IRS regulations. The following amounts will be listed on your paycheck as taxable income and are subject to federal income and Social Security tax withholding. These values have been adjusted to reflect the premium amounts taken after-tax (as explained above) so you are not taxed twice.

Healthcare Options

Taxable Benefit Amount – (WDS)

Domestic Partner/Same-Sex Spouse and Age 19-24 Year Old Child (Non-IRS Tax Dependent) Coverage Information

If your domestic partner/same-sex spouse, your age 19-24 year old children and/or your partner's non-IRS tax dependent's children do not qualify as your IRS tax dependents, you will also be taxed on the City-paid **value** of their medical, dental and vision coverage as required by IRS regulations.

The following amounts will be listed on your paycheck as taxable income and are subject to federal income and Social Security tax withholding. These values have been adjusted to reflect the premium amounts taken after-tax (as explained above) so you are not taxed twice.

Coverage Value with Washington Dental Services Coverage

2010 Monthly Taxable Values of City Coverage Provided to: Your Non-IRS Tax Dependent Domestic Partner/Same-Sex Spouse, Your Age 19-24 Year Old Non-IRS Tax Dependent Child, or Your Domestic Partner's Non-IRS Tax Dependent's Child		
Type of Coverage	**Domestic Partner/ Same-Sex Spouse Taxable Amount**	**Taxable Amount Per Child**
Preventive Plan	$393.88	$177.70
Traditional Plan	$369.16	$160.60
GHC Standard	$398.49	$179.99
GHC Deductible	$382.42	$165.73
WDS Coverage	$ 56.33	$ 33.80
Vision Coverage	$ 3.33	$ 2.00
Total Taxable Value with WDS & VSP		
Preventive Plan	$453.54	$213.50
Traditional Plan	$428.82	$196.40
GH Standard Plan	$458.15	$215.79
GH Deductible Plan	$442.08	$201.53

Healthcare Options

Taxable Benefit Amount – (DHS)

Domestic Partner/Same-Sex Spouse and Age 19-24 Year Old Child (Non-IRS Tax Dependent) Coverage Information

Coverage Value with Dental Health Services Coverage

2010 Monthly Taxable Values of City Coverage Provided to: Your Non-IRS Tax Dependent Domestic Partner/Same-Sex Spouse, Your Age 19-24 Year Old Non-IRS Tax Dependent Child, or Your Domestic Partner's Non-IRS Tax Dependent's Child		
Type of Coverage	**Domestic Partner/ Same-Sex Spouse Taxable Amount**	**Taxable Amount Per Child**
Preventive Plan	$393.88	$177.70
Traditional Plan	$369.16	$160.60
GHC Standard	$398.49	$179.99
GHC Deductible	$382.42	$165.73
DHS Coverage	$ 58.78	$ 35.27
Vision Coverage	$ 3.33	$ 2.00
Total Taxable Value with DHS & VSP		
Preventive Plan	$455.99	$214.97
Traditional Plan	$431.27	$197.87
GH Standard Plan	$460.60	$217.26
GH Deductible Plan	$444.53	$203.00

Plan Comparison Examples

The following matrix compares the plans in four different scenarios where employees would use services: a routine physical exam, a regular office visit (such as for an illness), outpatient treatment at a hospital, and surgery performed by a specialist. Costs for each service are compared by plan. For a more complete summary of benefits by plan, see the matrix that follows this example.

	PREVENTIVE PLAN		**TRADITIONAL PLAN**		**GROUP HEALTH COOPERATIVE**	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**	**GHC Deductible Plan**	**GHC Standard Plan**
Individual deductible	$100	$450	$400	$1,000	$200	None
Family deductible	$300	$1,350	$1,200	$3,000	$600	None
Routine physical exam	Paid at 100%	Paid at 60% after satis-faction of deductible for mammogram and ob/gyn exams only.	Paid at 80% after satisfaction of deductible for mammogram only. No other preventive care covered.	Paid at 60% after satisfaction of deductible for mammogram only. No other preventive care covered.	Paid at 100% after $15 copay and satisfaction of deductible (copay applies to deductible)	Paid at 100% after $15 copay
Office visit	Paid at 100% after $15 copay	Paid at 60% after satisfaction of deductible	Paid at 80% after satisfaction of deductible	Paid at 60% after satisfaction of deductible	Paid at 100% after $15 copay and satisfaction of deductible (copay applies to deductible)	Paid at 100% after $15 copay
Outpatient treatment at a hospital	Physician charges paid at 100% after $15 co-pay. After satisfaction of deductible, other charges paid at 90%.	After satisfaction of deductible, physician and other charges paid at 60%.	After satisfaction of deductible, physician and other charges paid at 80%.	After satisfaction of deductible, physician and other charges paid at 60%	After satisfaction of deductible and $15 copay (copay applies to the deductible), physician and other charges paid at 100%.	Paid at 100% after $15 copay.
Inpatient Surgery performed by a specialist in one of the 12 Aexcel specialty areas	**Aexcel specialist:** Paid at 90% after $200 inpatient copay **Non-Aexcel specialist:** Paid at 80% after $200 inpatient copay	Paid at 60% after $200 inpatient copay and satisfaction of deductible.	**Aexcel specialist**: Paid at 80% after $200 copay. **Non-Aexcel** Paid at 70% after $200 copay.	Paid at 60% after $200 inpatient copay and satisfaction of deductible.	Paid at 100% after satisfaction of deductible.	Paid at 100% after $200 inpatient copay

2010 Medical Benefits Highlights - Most City of Seattle Employees

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp.

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)					
No Deductible	$200 per person $600 per family Deductible applies except for prescriptions, preventive visits, ambulance, and durable medical equipment, except as noted.	$400 per person $1,200 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$1,000 per person $3,000 per family	$100 per person $300 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$450 per person $1,350 per family
Annual Out of Pocket Maximum (OOP Max) Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max.					
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,000 per person $3,000 per family	$2,000 per person* $6,000 per family*	$2,000 per person $4,000 per family	$3,000 per person* $6,000 per family*
Maximum Lifetime Benefits Payable					
Combined $2,000,000 lifetime maximum for Standard and Deductible plans		Combined $2,000,000 lifetime maximum in- and out-of-network for Traditional and Preventive plans			
Hospital Copay					
$200 per admission	Deductible applies	$200 copay per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission
Hospital Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by GHC		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers					
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.		Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.
COVERED EXPENSES					
Acupuncture					
$15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral.	$15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral. Deductible applies.	Paid at 80% Maximum of 60 visits per calendar year in- and out-of-network combined. Provider must submit medical necessity statement at 20th visit.	Paid at 60%	Paid at 100% after $15 copay Maximum of 60 visits per calendar year in- and out-of-network combined. Provider must submit medical necessity statement at 20th visit.	Paid at 60%
Alcohol/Drug Abuse Treatment					
Inpatient: Paid at 100% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 100% after deductible Outpatient: Paid at 100% after $15 co-pay. Deductible applies.	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Contraceptives					
For contraceptive drugs and devices, see Prescription Drug benefit		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.	
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Emergency Medical Care					
➢ **Urgent Care Clinic**					
Paid at 100% after $15 copay	$15 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay (no fee for preventive care)	Paid at 60%
➢ **Emergency Room (copays waived if admitted)**					
GHC facility: $100 copay Non-GHC facility: $150 copay	GHC facility: $100 copay Non-GHC facility: $150 copay Deductible applies	Paid at 80% after $150 copay	Paid at 80% after $150 copay. If non-emergency, paid at 60% after copay.	Paid at 90% after $150 copay	Paid at 90% after $150 copay. If non-emergency, paid at 60% after copay.
➢ **Ambulance**					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Hearing Aids (per ear, every 36 months)					
Up to $1,000	Up to $1,000	Up to $1,000 In-network coinsurance applies whether purchased in or out-of-network. Deductible does not apply.	Up to $1,000	Up to $1,000 In-network coinsurance applies whether purchased in or out-of-network. Deductible does not apply.	Up to $1,000
Home Health Care					
Paid at 100% when authorized. No visit limit.	Paid at 100% when authorized. No visit limit.	Paid at 80% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 60%	Paid at 90% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 60%
Hospital Inpatient					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible.	Paid at 80% after $200 copay. Physician services paid at 70% if Aexcel** specialist not used in specialty areas.	Paid at 60% after $200 copay	Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel** specialist not used in specialty areas.	Paid at 60% after $200 copay
Hospital Outpatient					
Paid at 100% after $15 copay	$15 copay. Deductible applies.	Paid at 80% after deductible. Physician services paid at 70% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible	Paid at 90% after deductible. Physician services paid at 80% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% Lifetime maximum of 6 months or $10,000, whichever is greater. 14-day inpatient limit; 120-hour outpatient limit.	Paid at 60%	Paid at 90%	Not covered
Maternity Care (delivery & related hospital)					
Paid at 100% after $200 copay	Deductible applies.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Maternity Care (prenatal and postpartum)					
Paid at 100% after $15 copay	$15 copay. Deductible applies.	Paid at 80%	Paid at 60%	Paid 100% after one $15 copay	Paid at 60%
Mental Health Care (inpatient)					
Paid at 100% after $200 copay	Paid at 100% after deductible.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Mental Health Care (outpatient)					
Paid at 100% after $15 copay per individual, family or couple session.	$15 copay per individual, family or couple session. Deductible applies.	Paid at 80% after deductible. Coinsurance does not apply to OOP Max.		Paid at 100% after $15 copay	Paid at 60% after deductible. Coinsurance applies to OOP Max.
Physician Office Visit					
Paid at 100% after $15 copay.	Paid at 100% after $15 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay per visit (waived for preventive care)	Paid at 60%
Prescription Drugs (retail)					
For a 30 day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay.	For a 30-day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay.	For a 31-day supply: **Generic**: 30% coinsurance. **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug. Coinsurance applies to the prescription $1,200 out-of-pocket annual maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment). City pays $20 per month, and plan participant pays remaining; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan benefit. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy.	Not covered	For a 31-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug.	Not covered
Prescription Drugs (mail order)					
For a 90 day supply: **Generic**: $45 copay **Brand:** $90 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the OOP Max.	For a 90 day supply: **Generic**: $30 copay **Brand:** $60 copay	For a 90-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.	Not Covered	For a 90-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.	Not Covered
Preventive Care					
Paid at 100% after $15 copay Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening.	Paid at 100% after $15 copay Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening Hearing exams subject to deductible.	Mammograms paid at 80%. No other preventive services are covered	Mammograms paid at 60%	Paid at 100% (copay waived) Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening.	Paid at 60% for well woman care and mammograms. No other preventive services covered
Rehabilitation Services (inpatient)					
Paid at 100% after $200 copay per admission Maximum of 60 days per calendar year (combined with other therapy benefits)	Paid at 100% after deductible.	Paid at 80% after $200 copay Maximum of $50,000 per condition for in- and out-of-network combined	Paid at 60% after $200 copay	Paid at 90% after $200 copay Maximum of 120 days per calendar year for in- and out-of-network combined	Paid at 60% after $200 copay

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Rehabilitation Services (outpatient)					
Paid at 100% after $15 copay	$15 copay Maximum of 60 visits per calendar year (combined with other therapy benefits)	Paid at 80% Includes physical/massage, speech, and occupational therapy. Maximum of 60 visits combined per calendar year. Coinsurance does not apply to OOP Max. Provider must provide medical necessity statement at 20th visit.	Paid at 60%	Paid at 100% after $15 copay Includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum of 60 visits combined per calendar year including in- and out-of-network. Provider must submit medical necessity statement at 20th visit.	Paid at 60%
Skilled Nursing Facility					
Paid at 100%. 60 day maximum per calendar year.	60 day maximum per calendar year. Paid at 100% after deductible.	Paid at 80% after $200 copay Maximum of 90 days per calendar year for in- and out-of-network combined	Paid at 60% after $200 copay	Paid at 90% after $200 copay Maximum of 120 days per calendar year for in- and out-of-network combined	Paid at 60% after $200 copay
Smoking Cessation					
Paid at 100% for individual or group sessions Nicotine replacement therapy included in Prescription Drug benefit	Paid at 100% for individual or group sessions	Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic, 20% brand drugs. See Prescription Drugs, retail.	Not covered	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	Not covered
Spinal Manipulations					
Paid at 100% after $15 copay Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	$15 copay. Deductible applies.	Paid at 80% Maximum of 10 visits per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $15 copay Maximum of 20 visits per calendar year for in-network and out-of-network combined.	Paid at 60%
Sterilization Procedures					
Outpatient: Paid at 100% after $15 copay	Outpatient: $15 copay. Deductible applies.	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Tooth Injury (due to accident)					
Not covered	Not covered	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay for office visit. Other charges paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Vision Hardware					
Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Covered under Vision Service Plan.		Covered under Vision Service Plan.	
X-ray and Lab Tests					
Paid at 100%	Paid at 100%. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

** Applies to Aetna – Aexcel network, a specialty network of doctors in 13 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the 13 specialty areas (coinsurance applies to in-network, out-of-pocket maximum).

Prescription Drug Plans

Prescription Drug Retail Program

Preventive and Traditional Plans (Aetna)

Aetna classifies medications into three tiers:

- Generic
- Preferred brand-name
- Non-preferred brand-name

Group Health Cooperative uses two classifications:

- Generic
- Preferred brand-name (no coverage for non-preferred brands)

With the Aetna plans, you pay 30% of the actual cost for generic drugs, and 40% for preferred and non-preferred brand-name drugs (up to a maximum of $100 per drug per month). There is a $1,200 annual out-of-pocket maximum per member for retail and mail order drugs.

There is an exception for two drug classes—proton pump inhibitors and non-sedating antihistamines. The City will pay $20 towards the cost of these drugs and you pay the remaining amount, whether you purchase the medication over the counter or as a brand name drug with a prescription from your doctor.

Present your ID card at any Aetna network pharmacy. Prescriptions filled at a non-network pharmacy will not be covered. You may contact the toll-free Member Services number on the back of your ID card to find a participating pharmacy, or check the website www.aetnanavigator.com

GHC Plans

You are responsible for a $15 copay for generic drugs and a $30 copay for brand name drugs. All prescriptions must be filled at a GHC pharmacy. Prescriptions filled at any non-GHC pharmacy will not be covered.

Prescription Drug Plan Comparison

Plan Features	GHC Standard	GHC Deductible	Aetna Preventive	Aetna Traditional
Annual out-of-pocket Maximum	Copays do not apply to out-of-pocket maximum.	Copays do not apply to out-of-pocket maximum.	$1200	$1200
Retail				
• **Coinsurance**	You pay $15 copay for generic drugs; $30 copay for brand name drugs.	You pay $15 copay for generic drugs; $30 copay for brand name drugs.	You pay 30% of actual cost of generic drug; 40% of cost for brand drugs*	You pay 30% of actual cost of generic; 40% of cost for brand drugs*
• **Minimum Coinsurance**	Not applicable	Not applicable	$10 or actual cost of drug if less.	$10 or actual cost of drug if less
• **Monthly out-of-pocket Maximum**	Copays do not apply to out-of-pocket maximum.	Copays do not apply to out-of-pocket maximum.	$100 per prescription	$100 per prescription
• **Days Supply**	30-day	30-day	31-day	31-day
• **Out-of-Network**	Not covered	Not covered	Not covered	Not covered
Mail Order				
• **Coinsurance**	Generic:$45 copay Brand: $90 copay	Generic:$30 copay Brand: $60 copay	You pay 30% of actual cost of generic drug; 40% of cost for brand drugs	You pay 30% of actual cost of generic; 40% of cost for brand drugs
• **Minimum Coinsurance**	Not applicable	Not applicable	$30 or actual cost of drug if less.	$30 or actual cost of drug if less.
• **Monthly out-of-pocket Maximum**	Copays do not apply to out-of-pocket maximum.	Copays do not apply to out-of-pocket maximum.	$200 per prescription	$200 per prescription
• **Days Supply**	90-day supply	90-day supply	90-day supply	90-day supply
• **Out-of-Network**	Not covered	Not covered	Not covered	Not covered

*Coinsurance exceptions:

- City pays $20 towards cost of proton pump inhibitors and non-sedating antihistamines and you pay the remaining amount, whether medication is purchased over-the-counter or is a brand name drug.

- You pay 10% of cost for generic and 20% for brand drugs for anti-high cholesterol, asthma, and tobacco cessation drugs; diabetic drugs and supplies: $5 copay for generic, $15 copay for brand.

Dental Options

You may choose between two dental plans - Washington Dental Service (WDS) and Dental Health Services (DHS) - for your dental coverage.

Washington Dental Service
If you select WDS, you can choose any dentist, but your out-of-pocket expenses may be lower if you choose a dentist who belongs to the WDS network.

Selecting a WDS dentist means:

- The portion of the dentist bill you pay is smaller than if you use a non-network dentist.
- You do not need to submit a claim - the dentist's office will submit the claim form.
- After you pay your portion of the bill, the dentist will not bill you more for a covered service. (A non-WDS dentist may bill you for the portion of the bill that WDS does not cover.)

Payment of Basic Services

The WDS Plan is designed to encourage regular dental care. Each calendar year of your employment (January 1 through December 31) WDS pays an increasing share of certain dental costs up to 100%. During the first calendar year, allowable diagnostic and preventive services are covered at 70% after the $50 annual deductible*, even if you had WDS coverage through a previous employer*. Each year the payment level advances 10% up to 100% as long as the eligible person obtains regular dental care and the $50 annual deductible is met. For example, if you satisfy the deductible and use the plan's benefit during the first year, the plan pays 70%. If you satisfy the deductible and use the plan's benefits during the second year, the plan then pays 80%.

If you fail to use basic services in a calendar year, the payment level will decrease 10% the following year. Payment levels will increase only if benefits are utilized in that year. However, the payment level will not drop below 70%.

Orthodontia

WDS offers orthodontia benefits for dependent children. Pre-treatment estimates are recommended. The orthodontia benefit is paid at a 50% level to a lifetime maximum of $1,500 for each eligible child. There is no adult orthodontia coverage.

Dental Options

	Dental Health Services The Dental Health Services Plan provides greater benefits for services received in network than if you enroll in WDS, but the DHS network of participating dentists is smaller. Selecting a Dental Health Services dentist means: • There are no deductibles or annual maximums. • Coverage does not decrease if you do not visit your dentist regularly.
Payment of Basic Services	This plan has an office visit copay of $10 for all employees. There are also copays for selected services. The plan comparison on the next page lists services and copay requirements.
Orthodontia	DHS offers both child and adult (age 25 and over) orthodontia. Orthodontia charges include: a copayment of $1,800 per adult or $1,000 per child for orthodontic treatment; a $150 charge for the initial exam, study models and X-rays; and a $10 copay for each visit during the course of treatment.
Dental Plan Comparison	The table on the next page compares the coverages offered by the two dental plans.

Dental Plan Comparison

Plan Features	Washington Dental Service (WDS)	Dental Health Services (DHS)
Calendar Year Deductible	$50 per person, $150 per family (No deductible for preventive services)	$0
Annual Maximum Benefit	$2,000 per person per year	No Annual Maximum.
Diagnostic and Preventive (routine and emergency exams, x-rays, cleaning, fluoride treatment, sealants)	Incentive payments levels 1st Year – 70% 2nd Year – 80% 3rd Year – 90% 4th Year – 100%	$10 office visit copay covers composite fillings in all teeth (posterior composite fillings additional $15) Two additional cleanings for pregnant women, up to four cleanings.
Crowns, Inlays, Onlays	Constant 70%	$75 (plus $70 noble, $100 high noble, $125 upgraded, specialize porcelain if applicable per unit.)
Prosthodonic Services (Dentures, Bridges)	Constant 50%	$125 plus $10 office visit copay (dentures) $75 plus $10 office visit copay (bridges) ($70 on noble, $100 on high noble metal & titanium, and $125 charge on upgraded, specialized porcelain)
Orthodontia	Dependent Child(ren) Only	Available for Child & Adult
	Plan pays 50%	Adult (age 25 and over) $1,800 plus $150 for initial exam, study models and x-rays covers full course of treatment plus $10 copay for each visit (new cases) Orthodontia cases (less than age 25) $1,000 copay $150 for initial exam, study models and x-rays covers full course of treatment plus $10 copay for each visit (new cases)
Lifetime Maximum	$1,500	N/A
Choice of Providers	In-Network: Any contracted provider. Out-of-Network: Expenses paid will be based on actual charges or Washington Dental Service's maximum allowable fees for nonparticipating dentists, whichever is less. You will be responsible for any balance remaining.	In-Network: Any contracted provider in the DHS network. Out-of-Network: No out-of-network coverage.

Dental Plan Comparison (continued)

Plan Features	Washington Dental Service (WDS)	Dental Health Services (DHS)
Periodontics (surgical and nonsurgical procedures for treatment of the tissues supporting the teeth)	Paid according to incentive payment levels shown above	Paid at 100% after $25 copay for periodontal scaling and maintenance at general dentist. If referred to periodontist, member pays 20%.
Endodontics (treatment of tissues surrounding root of tooth)	Paid according to incentive payment levels shown above, Root canal treatment of same tooth covered only once in a 2-year period.	Paid at 100% after applicable copay ($50 for anterior, $75 for bicuspid, or $100 for molar root canal) If referred to endodontist, member pays 20%.
Oral Surgery (routine and surgical extractions)	Paid according to incentive payment levels shown above, Root canal treatment of same tooth covered only once in a 2-year period.	Paid at 100% after $10 office visit copay for general dentist. If referred to an oral surgeon, member pays 20%
Temporomandibular Joint (TMJ) Disorders	Not covered	$1,000 annual maximum $5,000 lifetime maximum

2010 Monthly Dental Premiums

Dental Plan	Total Monthly Premium Amount	Employee's Monthly Premium Contribution	
		Coverage for Employee with or without children	Coverage for Employee with Spouse/Domestic Partner with or without children
Washington Dental Service	$128.43	$0	$0
Dental Health Services	$133.99	$0	$0

Vision Coverage

Vision Service Plan	Vision coverage is fully paid by the City and benefits are provided under the Vision Service Plan (VSP). If you use a VSP provider, you will receive the benefits listed in the following table. If you use a non-VSP provider, the Plan will reimburse you for expenses in the amounts shown.
Plan Ahead	Any lens options such as scratch coating, anti-reflective coating, no-line bifocals, or high density plastic as not covered by the plan. If you want any features not covered by the plan, plan ahead and use your FSA to pay for it with pre-tax dollars.

Vision Benefits

Plan Features	VSP Provider	Non-VSP Provider
Eye exam: Covered each calendar year	$10 copay. Exam covered in full.	Covered up to $45.
Lenses and Frames: Covered every other calendar year	$25 copay. Single vision, lined bifocal, lined trifocal lenses are covered in full. Frames covered in full up to contract lens allowance of $150.	$25 copay. Lenses covered up to $45 - $85 depending on type of lens. Frames covered up to $47.
Contact Lenses: Covered every other calendar year	Full payment of eye exam, contact lens evaluation exam, fitting & materials covered up to contract allowance of $120.	Covered up to $105; includes contact lens evaluation exam, fitting and materials.

2010 Monthly Vision Premiums for Most City Employees

Vision Plan	Total Monthly Premium Amount	Employee's Monthly Premium Contribution	
		Coverage for Employee with or without children	Coverage for Employee with Spouse/Domestic Partner with or without children
Vision Service Plan	$7.59	$0	$0

Optional Insurance

Optional Insurance Choices	The City of Seattle offers paid Basic Long-Term Disability Insurance and shares the cost of Group Term Life Insurance with you.
Long-Term Disability (LTD)	The basic benefits package provided by the City includes a Long-Term Disability (LTD) policy that will pay you a portion of your monthly pay if you are sick or injured and cannot work. If you are disabled (according to the definition in the Plan), the Plan will combine with other sources of income to pay you $400 a month after a 90-day waiting period. Your maximum basic benefit will be $400 per month while you are unable to work.
Group Term Life (GTL) Insurance	The City benefits program includes Basic Life Insurance; you and the City share the cost. This optional coverage provides you with a Term Life Insurance benefit amount equal to one-and-a-half times your annual salary. The City contributes 40% of the cost and you pay the other 60% of the cost. A table with information regarding the monthly cost of Basic Term Life Insurance follows.
Basic Life Insurance	If you sign up for Basic Term Life Insurance when you are first eligible, you are guaranteed coverage. However, if you sign up for it later, you will be required to complete a Medical History Statement, which must be approved by the insurance company before your life insurance takes effect. If you have certain health conditions, you could be denied coverage. This policy includes a conversion privilege which allows you to continue some level of coverage if you leave City employment. Conversion is guaranteed, which means you can continue the policy regardless of any existing medical condition. It is more costly because of this provision, but could allow you to maintain coverage when you otherwise might not qualify for new life insurance coverage.
Limited Basic Life Insurance	IRS rules state that the value of Basic Life Insurance over $50,000, which is paid for by the City, is taxable. Because the City pays 40% of the cost for your Basic Term Life Insurance, you may have some taxable value. If you do, the amount on which you pay taxes will be shown on your second paycheck each month. You may limit your Basic Term Life Insurance coverage amount to $50,000 to avoid the additional taxes by signing a notarized Waiver form available from your department Human Resources Representative.

Optional Insurance

	Basic Group Life Insurance Costs				
Costs for Basic Life Insurance (based on employee's annual earnings)	**Employee's Annual Earnings**	**Insurance Amount**	**Employee Monthly Premium**	**City Monthly Premium**	**Total Monthly Premium**
	$48,000.01-$49,000	$73,500	$4.85	$3.23	$8.09
	$49,000.01–$50,000	$75,000	$4.95	$3.30	$8.25
	$50,000.01–$51,000	$76,500	$5.05	$3.37	$8.42
	$51,000.01–$52,000	$78,000	$5.15	$3.43	$8.58
	$52,000.01–$53,000	$79,500	$5.25	$3.50	$8.75
	$53,000.01–$54,000	$81,000	$5.35	$3.56	$8.91
	$54,000.01–$55,000	$82,500	$5.45	$3.63	$9.08
	$55,000.01–$56,000	$84,000	$5.54	$3.70	$9.24
	$56,000.01–$57,000	$85,500	$5.64	$3.76	$9.41
	$57,000.01–$58,000	$87,000	$5.74	$3.83	$9.57
	$58,000.01–$59,000	$88,500	$5.84	$3.89	$9.74
	$59,000.01–$60,000	$90,000	$5.94	$3.96	$9.90
	$60,000.01–$61,000	$91,500	$6.04	$4.03	$10.07
	$61,000.01–$62,000	$93,000	$6.14	$4.09	$10.23
	$62,000.01–$63,000	$94,500	$6.24	$4.16	$10.40
	$63,000.01–$64,000	$96,000	$6.34	$4.22	$10.56
	$64,000.01–$65,000	$97,500	$6.44	$4.29	$10.73
	$65,000.01–$66,000	$99,000	$6.53	$4.36	$10.89
	$66,000.01–$67,000	$100,500	$6.63	$4.42	$11.06
	$67,000.01–$68,000	$102,000	$6.73	$4.49	$11.22
	$68,000.01–$69,000	$103,500	$6.83	$4.55	$11.39
	$69,000.01–$70,000	$105,000	$6.93	$4.62	$11.55
	$70,000.01–71,000	$106,500	$7.03	$4.69	$11.72
	$71,000.01–$72,000	$108,000	$7.13	$4.75	$11.88

Your coverage amount is equal to your annual salary, rounded up to the next $1,000 increment, multiplied by 1.5. Your monthly premium equals $0.066 times each $1,000 of coverage.

For example, if your salary is $78,600 per year, round it up to $79,000. Your coverage amount is $118,500 (Calculation: $79,000 x 1.5 = $118,500). Your premium is $7.78 per month (Calculation: $0.066 x 118).

Retirement

Deferred Compensation Savings Plan

The City offers two programs to help you prepare financially for retirement: the Deferred Compensation Program and the City's

You may participate in an IRS Section 457 Deferred Compensation Plan administered by Prudential Retirement. This plan allows you to save a portion of your annual income to supplement retirement funds. Contributions are made through payroll deductions from your pre-tax gross pay. You have the choice of several investment options to diversify your savings. For more information regarding the Deferred Compensation Plan contact Prudential at 1-800-833-5761.

- You may enroll, as well as start and stop your contributions to this program, at any time.
- You many contribute as little as $20 per month and as much as 50% of your annual taxable income up to the annual limit shown below to supplement your retirement funds.
- You do not pay federal income tax on your money until it is withdrawn.
- You can apply for a loan, not to exceed the lesser of $50,000 or half your account balance.
- You are eligible to withdraw your money only when you leave City service, regardless of age and with no tax penalty. (Hardship withdrawals are subject to IRS rules and approval by the Plan trustees.)

Year	Contribution Limit under age 50	Contribution Limit over age 50
2010	$16,500	$5,500

Retirement

Seattle City Employees' Retirement System

There are four opportunities when a temporary employee may elect membership in the Seattle City Employees' Retirement System

1. When first hired into City employment
2. At the completion of 1,044 hours of City employment, the equivalent of 6 months full-time work
3. After completing 10,440 hours of City employment, the equivalent of 5 years full-time work
4. When appointed to a regular position of City employment, you may join the Retirement System and purchase prior credit, provided this occurs before completion of 10,440 hours of City employment.

Contact the Retirement Office (386-1292) for more information.

Retirement System Death Benefit

Active employees are automatic members of the Death Benefit Program. Retirees may choose whether or not to retain this policy. The intended purpose of this policy is to be an adjunct to your burial insurance. The benefit is $2,000 and payable only to the beneficiary. The premium is $12.00 per year, deducted in February. The policy has no cash value for the retiree.

Leave Programs

Vacation

You begin accumulating vacation as soon as you no longer receive premium pay in lieu of benefits. You can use vacation, with supervisory approval, as provided by SMC 4.34.045. Your vacation accrual rate shall include credit for all regular straight-time hours worked since your initial appointment to City employment.

Unused vacation balance remaining at the end of your benefit-eligible assignment shall be cashed out at the straight-time rate of pay you received on the last day worked in this assignment unless you are hired into a regular position that is eligible for vacation accrual without a voluntary break in service.

The chart below shows vacation accrual. You accumulate vacation based on a maximum of 80 hours per pay period.

Hours of Regular Pay Status	Vacation Accrued per Hour	Years of Service	Days per Year	Hours	Maximum Balance
Less than 08321	.0460	0 to 4	12	96	192
08321 to 18720	.0577	5 to 9	15	120	240
18721 to 29120	.0615	10 to 14	16	128	256
29121 to 39520	.0692	15 to 19	18	144	288
39521 to 41600	.0769	20	20	160	320
41601 to 43680	.0807	21	21	168	336
43681 to 45760	.0846	22	22	176	352
45761 to 47840	.0885	23	23	184	368
47841 to 49920	.0923	24	24	192	384
49921 to 52000	.1000	25	25	200	400
52001 to 54080	.1038	26	26	208	416
54081 to 56160	.1038	27	27	216	432
56161 to 58240	.1076	28	28	224	448
58241 to 60320	.1115	29	29	232	464
60321 and over	.1153	30	30	240	480

Note: You may use available vacation in minimum increments of 15 minutes to 4 hours with supervisory approval (or as defined by applicable bargaining unit contract).

Leave Programs

Sick Leave	Sick leave is a short term disability insurance program that covers your wages when you must be absent from work due to personal illness, injury or disability. You may also use sick leave when you must be absent due to illness, injury or disability of your spouse/domestic partner, parent or dependent child. Sick leave may also be taken to cover time missed for your medical or dental appointments or to accompany your eligible family member(s) to medical or dental appointments. You accrue sick leave at the rate of .046 hours for each hour on regular non-overtime pay status to a maximum of 80 hours per pay period. Accrual begins when your assignment becomes benefits eligible. There is no maximum accumulation; you may carry over your sick leave balance from year to year. Any accumulated and unused sick leave remaining at the end of your assignment shall be held in abeyance until you are hired into another benefits-eligible assignment. Upon separation from the City for any reason other than service retirement, you will forfeit any accumulated unused sick leave balance. If you retire from City service, you will receive an after-tax cash out of 25% of your sick leave balance.
Holidays	Most City employees are eligible for 10 official paid holidays and two personal paid holidays per year. To qualify for a paid holiday, you must be on regular pay status either the day before or the day after the observed holiday. However, if you returned the day after a holiday, but had been on unpaid leave for more than four days immediately preceding the holiday, you would not be eligible for holiday pay. You will receive two personal holidays when you become eligible for benefits if you have not already received personal holidays in another assignment within the same calendar year. Personal (floating) holidays must be used during the calendar year or you will forfeit them. You must use your personal holidays before your benefits-eligible assignment ends.

Leave Programs

Holidays

Here is the 2010 holiday schedule.

New Year's Day	Friday, 1/01/2010
Martin Luther King Jr. Day	Monday, 1/18/2010
President's Day	Monday, 2/15/2010
Memorial Day	Monday, 5/31/2010
Independence Day	Monday, 7/05/2010
Labor Day	Monday, 9/06/2010
Veterans' Day	Thursday, 11/11/2010
Thanksgiving Day	Thursday, 11/25/2010
Day following Thanksgiving	Friday, 11/26/2010
Christmas Day Observed	Friday, 12/24/2010
New Years Day 2010	Friday, 12/31/2010

Other Leave Policies

Funeral Leave

You are permitted time off without loss of pay or paid leave balances to attend the funeral of a close relative. With supervisory approval, you may use up to five days of accumulated sick leave to attend the funeral of a relative other than a close relative.

Jury Duty

If you serve on jury duty during normal work hours, you will be paid your regular straight-time pay upon surrendering to the City any compensation you receive from the Court, less transportation allowance.

Family and Medical Leave

You are eligible for Family and Medical Leave after six calendar months of employment.

Work Life Programs

Trip Reduction Program	The City of Seattle encourages employees to use alternatives to driving alone to work. City of Seattle employees are eligible to receive a transit subsidy up to the equivalent of a one-zone peak monthly Metro bus pass. To sign up for payroll deduction for a monthly or annual transit pass, log on to the Employee Self Service webpage (instructions at http://inweb/sdot/ctr/transit.htm). Eligible employees may purchase an ORCA card at a variety of locations in the City, listed here: http://inweb/sdot/ctr/bus.htm . The Internal Revenue Code allows up to $115 per month (less City subsidy) for transit passes to be deducted from paychecks on a pre-tax basis. Once the deduction has been withheld from your paycheck, the IRS will not allow you to revoke the deduction or receive a refund. Any amount over the allowable maximum will be deducted from post-tax dollars. Actual savings will vary depending on your federal tax filing status and the amount of the transit pass. Employees who purchase a payroll-deducted transit pass are automatically enrolled in the pre-tax plan.
ZipCar	City employees can get a discounted membership in Zipcar. The City will pay the application and annual fees. Your monthly costs as a member will vary depending on how much you use the ZipCar vehicles. Use a rideshare mode to get to work. Then use ZipCar to go to doctor appointments, do special errands during the day, or drive home after working an extended day. ZipCar vehicles are located throughout Seattle and in Bellevue. You'll have access to the entire ZipCar fleet on evenings and weekends. For more information and to apply online, go to www.zipcar.com/cityofseattle .

GLOSSARY

Balance billing	The amount over and above your co-insurance amount that you may be required to pay if you use a non-network provider. See the explanation for **Paying an Out-of-network provider** at the end of this Glossary.
Coinsurance	The arrangement by which both the Plan and the employee share a specified ratio of the covered expenses under the policy. For example, the Aetna Open Choice Traditional Plan pays 80% of most covered expenses while the employee pays the remaining 20% of covered expenses once the deductible has been met.
Copayment	A fee paid at the time a medical or dental service is provided. A copayment may be a percentage of charges, but is usually a flat fee. In general, copayments may not be applied toward the coinsurance or out-of-pocket deductibles.
Deductible	The amount of covered expenses that must be incurred before benefits are paid by the Plan. The deductible is set on an annual basis and there are individual and family deductibles.
Eligible Expenses	Expenses as defined in the health plan as being eligible for coverage. This could involve specified health services fees or "reasonable and customary charges."
Formulary	A list of preferred brand-name and generic drugs. Drugs are selected for inclusion based on evaluation criteria developed by each Plan. Formularies are different depending on the Plan, and may change to include new drugs or to drop brand-name drugs as generic equivalents become available.
Generic Drug	A drug which contains the same active ingredients in the same amounts as the brand-name product, although it may differ in color, shape or size from the brand-name product. It is produced after the brand name drug's patent has expired. It is also called a "generic equivalent."
Network Provider	A medical provider, such as a physician, who has a signed contract to participate in a health plan. Also known as a preferred provider.
Non-network Provider -	A provider who has not signed a contract with a health plan. Also known as a non-preferred provider.
Out-of-Pocket Cost	The amount not covered by the plan that the plan member pays. This includes such things as coinsurance, deductibles, etc.
Out-of-Pocket	The amount of copays and/or coinsurance an individual will be

Limit (Out-of-Pocket Maximum)	required to pay within a calendar year before most covered expenses are covered in full.
Pre-existing condition	A physical condition that existed prior to the effective date of a policy. In many health policies these are not covered until after a stated period of time has elapsed. The City's medical plans cover all pre-existing conditions.
Preferred Provider	A medical provider, such as a physician, who has a signed contract to participate in a health plan. Also known as a network provider
Preventive Care	Care that consists of routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur.
Recognized Charge	The charge determined by Aetna on a semiannual basis to be in the 70th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

PAYING OUT OF NETWORK CLAIMS

The following is an explanation of how out-of-network claims are paid by Aetna. This will explain how "Recognized Charges" are used, and how the amount that you are "balance billed" is calculated.

Explanation of Terms

Recognized Charge - The charge determined by Aetna on a semiannual basis to be in the 70th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished. The 70th percentile is determined by the maximum amount that 70% of providers charge for a particular service in the geographic area where the service is provided. For example, if 70% of the doctors in a specific area charge $100 or less for an office visit, the Recognized Charge at the 70th percentile would be $100.

Out-of-network reimbursement level – The percentage of the "Recognized Charge" that Aetna will reimburse an out-of-network provider. Aetna uses 60% of the "Recognized Charge" for most eligible claims. The member pays the remaining 40% of the "Recognized Charge."

Out-of-network provider – A provider who does not have a contractual reimbursement relationship with Aetna. When Aetna receives a claim from an out-of-network provider, Aetna determines the "Recognized Charge" and pays 60% of that amount if the out-of-pocket maximum has not been satisfied, even though the provider may actually charge more that the "Recognized Charge."

Out-of-pocket maximum – The amount a member must pay before the out-of-network reimbursement level becomes 100% for most eligible expenses. This amount varies according to the plan. Before the out-of-pocket maximum is reached, the member pays 40% of the "Recognized Charge" for most eligible expenses. As explained below, the difference between a provider's actual charge and the "Recognized Charge" will NOT apply toward the out-of-pocket maximum.

Example of how an out-of-network office visit charge is paid.

Data to use to calculate the reimbursement amount:

- Out-of-network provider's actual charge: $100 (hypothetical number)
- Recognized Charge: $ 85 (hypothetical number)
- Out-of-network reimbursement level: 60%

How the claim is paid (for a $100 office visit):

1. Aetna will pay 60% of $85, i.e., $51
2. Member pays 40% of $85, i.e., $34. The $34 is applied to the out-of-pocket maximum.
3. Member may also have to pay the difference between the doctor's actual charge ($100) and the Recognized Charge ($85), i.e., $15. The $15 would not apply to the out-of-pocket maximum.

The member pays the $15 only if the doctor bills the member (this is balance billing). Upon receipt of the bill for $15, the member can try to negotiate a reduction or elimination of the charge with the doctor.

If you have questions about any of the information in this booklet please call the Benefits Unit at 206-684-1340.

Who to Contact if You Have a Question

If you have questions, contact the following organizations by phone or obtain information through their web sites. The Personnel Department's Central Benefits Unit can be reached at 615-1340.

Aetna	877-292- 2480	www.aetnanavigator.com
Group Health Cooperative	888 901-4636	www.ghc.org
Vision Service Plan	800- 877-7195	www.vsp.com click on "Members and Consumers"
Washington Dental Service (WDS)	206-522-2300 or 800-554-1907	www.ddpwa.com
Dental Health Services	206-788-3444 877-495-4455	www.dentalhealthservices.com/cityofseattle
Prudential Retirement Local Representative	800-833-5761 206-447-1924	www.prudential.com/online/retirement
Employee Assistance Program	206-654-4144 or 800-553-7798	http://www.eapfs.com Click on "I am an Employee" Username: "City of Seattle"
Life, AD&D, LTD		Your Department/HR Representative
Alternative Dispute Resolution	206-615-0089 206-615-1692 206-684-7888 TTY	http://inweb/personnel/programs/adr.asp
City's Central Benefits Unit	206-615-1340	http://inweb/personnel/benefits
Employee Self-Service		http://selfservice/

HEALTH CARE BENEFITS ELECTION FORM – MOST

Temporary Employees With Benefits Eligible Assignments

Last Name (Please Print) First Name | Employee Number | Department

Home Address - Street | City State | Zip

Hire Date | Work Phone | Birth Date (M/D/Y) | Social Security Number - -

☐ New Hire ☐ Re-Enrolling ☐ Decline coverage (*skip to Page 2*) Effective Date of Coverage _____

Reason for re-enrolling: ☐ Loss of other coverage (Attach proof of other coverage) ☐ Birth/adoption of child
☐ Marriage/new domestic partnership (Attach affidavit of marriage/domestic partnership)
☐ Other _____

Medical Plan Selection *(Please choose ONE Medical Plan below)*	**Employee Premium Share**
City of Seattle Preventive Plan	
☐ Employee Only (with or without Children)	$48.12
☐ Employee & Spouse/Domestic Partner (with or without Children)	$98.50
City of Seattle Traditional Plan	
☐ Employee Only (with or without Children)	$ - 0 -
☐ Employee & Spouse/Domestic Partner (with or without Children)	$32.34
Group Health Standard Plan	
☐ Employee Only (with or without Children)	$48.40
☐ Employee & Spouse/Domestic Partner (with or without Children)	$99.90
Group Health Deductible Plan	
☐ Employee Only (with or without Children)	$25.00
☐ Employee & Spouse/Domestic Partner (with or without Children)	$56.92
Vision Plan	
☐ Vision Service Plan	None
Dental Plan Selection *(Please choose ONE Dental Plan)*	
☐ Dental Health Services **OR** ☐ Washington Dental Service	None

Add Dependent Coverage Information: List all eligible dependents. Attach list for any additional dependents.

Spouse/Domestic Partner **Birth Date** **Enroll In** ☐**Yes** ☐**No** (Medical) ☐**Yes** ☐**No** (Dental/Vision)

Last Name First Name MI | Social Security Number | (M/D/Y)

Relationship

☐ **Spouse** ☐ Male ☐ Female **OR** ☐ **Domestic Partner** ☐ Male ☐ Female Partner claimed as IRS tax dependent ☐Yes ☐ No

1. Dependent Child **Birth Date** **Enroll In** ☐**Yes** ☐**No** (Medical) ☐**Yes** ☐**No** (Dental/Vision)

Last Name First Name MI | Social Security Number | (M/D/Y)

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** Is child employee's IRS tax dependent? ☐ Son ☐ Daughter ☐Yes ☐ No **OR** **Other** (Step-child or Legal ☐Male ☐ Female

THIS ENROLLMENT FORM IS NOT VALID UNLESS IT IS SIGNED AND DATED ON THE REVERSE SIDE

2. Dependent Child **Birth Date** **Enroll In**

☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

Last Name First Name MI Social Security Number (M/D/Y) Medical Dental/Vision

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** Is child employee's IRS tax dependent? ☐ Son ☐ Daughter ☐ Yes ☐ No **OR** **Other** (Step-child or Legal ☐ Male ☐ Female

3. Dependent Child **Birth Date** **Enroll In**

☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

Last Name First Name MI Social Security Number (M/D/Y) Medical Dental/Vision

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** Is child employee's IRS tax dependent? ☐ Son ☐ Daughter ☐ Yes ☐ No **OR** **Other** (Step-child or Legal ☐ Male ☐ Female

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Dependent Eligibility Information: If you have listed a dependent child over the age of 21 years, please answer the questions below about your dependent:

1. Married? ☐ Yes ☐ No
2. Income tax dependent? ☐ Yes ☐ No
3. Incapacitated or Disabled? ☐ Yes ☐ No
4. Full-time student at an accredited school? ☐ Yes ☐ No

Coverage Options

☐ **I ACCEPT COVERAGE**

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize the City to deduct from my earnings any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines.

_____ _____

Employee's signature Date

☐ **I DECLINE COVERAGE**

If you have medical coverage elsewhere and lose your other coverage, you may enroll within 30 days of the loss of the other coverage upon providing proof of continuous medical coverage. If you have a qualifying change in family status, you may enroll within 31 days (or 60 days for a new child) of that change. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law through the City. However, if you retire you will be eligible to enroll in a City retiree medical plan.

If you decline coverage and have no medical insurance elsewhere, you will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless you have a qualifying change in family status. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law or enroll in a City retiree medical plan.

I understand that by declining City of Seattle medical insurance, my medical coverage through the City will end, but my vision and dental insurance will continue.

I decline medical coverage for myself and family members.

_____ _____

Employee's signature Date

Department Representative's signature_____ Date Entered into HRIS _____

CITY OF SEATTLE
AFFIDAVIT OF MARRIAGE/DOMESTIC PARTNERSHIP

SECTION I

I,		certify that:
	(print name of employee)	

Complete either A for marriage or B for domestic partnership

A.

I, and		were legally married on	
	(print name of spouse)		(date of marriage)

- OR -

B.

I, and		have formed a domestic partnership **and** we:
	(print name of domestic partner)	

1. Share the same regular and permanent residence **and**
2. Have a close personal relationship **and**
3. Are jointly responsible for basic living expenses as defined below **and**
4. Are not married to anyone **and**
5. Are each eighteen (18) years of age or older **and**
6. Are not related by blood closer than would bar marriage in the state of Washington **and**
7. Were mentally competent to consent to contract when our domestic partnership began **and**
8. Are each other's sole domestic partners and are responsible for each other's common welfare.

"Basic living expenses" means the cost of basic food, shelter, and any other expenses of a Domestic partner, which are paid at least in part by a program or benefit for which the partner qualified because of the Domestic Partnership. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

SECTION II

A. I understand that this affidavit shall be terminated upon the death of my spouse/domestic partner or by a change of circumstance attested to in this affidavit.

I agree to notify my payroll/personnel representative if there is any change of circumstances attested to in this affidavit within thirty-one (31) days of change by filing a Statement of Termination of Marriage/Domestic Partnership.

B. After such termination, I understand that another Affidavit of Marriage/Domestic Partnership cannot be filed until ninety (90) days after a Statement of Termination of Marriage/Domestic Partnership has been filed with my payroll/personnel representative, unless such termination is due to the death of my spouse/domestic partner or the dissolution of my marriage.

____ C. I understand that if I have indicated on my Medical Benefit Election Form that my
initial domestic partner is my IRS tax dependent, he/she meets the IRS Section 152 definition of a dependent.

_____ D. I understand that if my domestic partner is not an IRS tax dependent that any employee
initial health premiums attributed to my domestic partner will be paid with after tax dollars.

SECTION III

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or if otherwise required by law.

We understand that this declaration of responsibility for our common welfare may have legal implications under Washington law.

We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit of Marriage/Domestic Partnership.

We also certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

I, the undersigned City of Seattle Employee, understand that willful falsification of information on this affidavit may lead to disciplinary action, up to and including discharge from employment.

Signature of Employee		Signature of Spouse/Domestic Partner
Address		Address
City, State Zip		City, State Zip
Employing Department		Employing Department (if applicable)
Date		Date

Send completed form to your HR Department

City of Seattle
Group Term Life Insurance Election Form

Last Name (Please Print) First Name | Employee No. | Department

Home Address - Street | City, State | Zip

Hire Date | Work Phone | Birth Date | Social Security Number

BASIC GROUP TERM LIFE INSURANCE

Effective date of coverage/change for: ☐ New Employee ☐Adding coverage ☐ Canceling coverage

☐ **YES**, I am applying for group term life insurance according to the terms of the group policy issued to the City of Seattle, with coverage equaling 1½ times my annual salary. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

☐ **NO,** I do not care to participate in the City of Seattle's group term life insurance plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

BASIC GROUP TERM LIFE INSURANCE -- LIMITED COVERAGE

Effective date of coverage/change for: ☐ New Employee ☐Adding coverage ☐Canceling coverage

☐ My gross salary is greater than $33,000, and I am applying for Basic GTL coverage limited to $50,000 (instead of the above Basic GTL coverage equal to 1½ times my salary) according to the terms of the group policy issued to the City of Seattle. I authorize premiums to be deducted from my salary. Previously submitted enrollment information for Basic GTL insurance, excluding current beneficiary information, is superseded by this election. I understand if I later want to increase my GTL coverage amount, I will be required to provide a Medical History Statement. My signed and notarized *Waiver Agreement* accompanies this application.

SUPPLEMENTAL GROUP TERM LIFE INSURANCE -- INDIVIDUAL COVERAGE*

Effective date of coverage/change for: ☐ New employee ☐Adding coverage
☐ Canceling coverage ☐Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for myself in the following amount according to the terms of the group policy issued to the City of Seattle. The coverage amount selected below does not exceed four times my annual salary rounded to the next lower multiple of $5,000 if not already a multiple of $5,000. ***I understand this coverage can only be purchased if I have also elected Basic GTL or Basic GTL - Limited Coverage***. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

Coverage Amount: $ Current Annual Salary: $

☐ **NO**, I do not care to participate in the City of Seattle's Supplemental GTL plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

SPOUSE OR DOMESTIC PARTNER COVERAGE*

Effective date of coverage/change for: ☐ New employee ☐Adding coverage
☐ Canceling coverage ☐Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for my spouse/domestic partner in the amount of **$** according to the terms of the group policy issued to the City of Seattle. **This coverage amount is at least $5,000 or a multiple of $5,000, and is *not greater* than 50% of my Individual Supplemental GTL coverage amount.** I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, and benefits for any loss are payable to me. I authorize deductions from my salary for contributions I am required to make toward the cost of this insurance.

☐ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for a spouse or partner. I understand that if I currently have a spouse or partner, s/he will be required to submit a Medical History Statement if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

DEPENDENT CHILD COVERAGE*

Effective date of coverage/change for: ☐ New employee ☐ Adding coverage
☐ Canceling coverage ☐ Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for my child(ren) or my spouse's/domestic partner's child(ren) in the amount selected below according to the terms of the group policy issued to the City of Seattle. I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, covered child(ren) must meet the eligibility criteria, and benefits for any loss are payable to me. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. (One amount covers all children)

☐ **$2,000** ☐ **$5,000** ☐ **$10,000**

☐ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for dependent children. I understand that if I currently have a dependent child(ren), I may apply for coverage later only during an annual open enrollment period.

BENEFICIARY INFORMATION

Effective date of beneficiary change

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. (You are the designated beneficiary for any spouse or partner, or dependent child loss.) Please specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, use a separate list, sign, date and attach to this form.

Beneficiaries for Basic Group Term Life

Last Name (Please Print)	First Name	Address	% of Benefit / ☐ Check if Contingent
Last Name	First Name	Address	% of Benefit / ☐ Check if Contingent

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Beneficiaries for Supplemental Group Term Life

Last Name (Please Print)	First Name	Address	% of Benefit / ☐ Check if Contingent
Last Name	First Name	Address	% of Benefit / ☐ Check if Contingent

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By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge, that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

Employee's signature _____ Date_____

I have completed and mailed the required Medical History Statement to the insurance company because:

☐ I am not a new employee and I am applying during open enrollment.
☐ I am not a new employee and I am applying for Spouse or Domestic Partner coverage during open enrollment.
☐ I am a new employee and the combined total of my Basic and Supplemental coverage exceeds $500,000.
☐ I am a new employee and the Supplemental coverage for my spouse/domestic partner exceeds $50,000.

Department Representative's signature_____ Date Entered into HRIS_____

*Temporary benefited employees (TBE) are not eligible for Supplemental, Spouse/DP, and Child GTL Coverage.

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
**CONTINUATION COVERAGE RIGHTS UNDER COBRA **

Introduction
It is important that all covered individuals (employee, spouse/domestic partner, and eligible dependent children, if able) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent not living at your address, please provide written notification to your department's Benefits Representative so a notice can be sent to that dependent as well.

You are receiving this notice because you have recently become covered under one or more of the following group health plans: City of Seattle Preventive Plan, City of Seattle Traditional Plan, Group Health Cooperative, Washington Dental Service, Dental Health Services, Vision Service Plan, and the Health Flexible Spending Account (Health FSA). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under a plan under certain circumstances when coverage would otherwise end due to a qualifying event. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plans listed above (medical, dental, vision, and the Health FSA) and not to any other benefits offered by the City of Seattle (such as life insurance, long term disability, or accidental death and dismemberment insurance). **Should an actual qualifying event occur in the future, the City of Seattle will send you additional information and an election notice at that time.**

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under a plan. It can also become available to your spouse/domestic partner and dependent children, if they are covered under a plan, when they would otherwise lose their group health coverage under the plan. This notice does not fully describe COBRA coverage or other rights under a plan. For additional information about your rights and obligations under a plan and under federal law, you should review the plan booklet or contact the City of Seattle Personnel Department Benefits Unit, which is the COBRA Plan Administrator. A plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed in this notice. After a qualifying event occurs and any required notice of that event is properly provided to your department's Benefits Representative, COBRA coverage must be offered to each person losing plan coverage who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under a plan is lost because of the qualifying event. Under a plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

Who is entitled to elect COBRA Continuation Coverage?
If you are an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason.

If you are the spouse/domestic partner, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because any of the following qualifying events happens:

- your spouse/domestic partner dies;
- your spouse's/domestic partner's hours of employment are reduced;
- your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse, or you terminate your domestic partnership. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation occurs within three months of the reduction or elimination of coverage, then the divorce or legal separation will be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under a plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under a plan as a "dependent child."

When is COBRA Continuation Coverage Available?
When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, a COBRA election notice will be made available to qualified beneficiaries. You do not need to notify the Benefits Representative in your department of the occurrence of any of these three qualifying events. However, notice must be provided to your department's Benefits Representative for other qualifying events, as explained below in the section entitled "You Must Give Notice of Some Qualifying Events."

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership, or a dependent child's loss of eligibility for coverage as a dependent child), a COBRA election notice will be available to you only if you complete and submit a *Health Care Benefits Change Form* to the Benefits Representative for your department within 60 days after the date on which the qualified beneficiary loses or would lose coverage under the terms of the plan as a result of the qualifying event. If this procedure is not followed during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE. (A *Health Care Benefits Change Form* is available from your department's Benefits Representative.)

Electing COBRA Coverage
Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses/domestic partners (if the spouse/domestic partner is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied.

How Long Does COBRA Coverage Last?
COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce, legal separation or termination of domestic partnership; or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months BEFORE the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse/domestic partner and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component."

Extension of Maximum Coverage Period
If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Disability extension of 18-month period of continuation coverage
If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above.)

The disability extension is available only if you complete and submit a *Notice of Disability* and a copy of the Social Security Administration's determination of disability to the COBRA Plan Administrator: (a) during the 18 months after the covered employee's termination of employment or reduction of hours, and (b) within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of a plan as a result of the covered employee's termination of employment or reduction of hours.

If these procedures are not followed or if the notice is not provided to the COBRA Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. You can obtain a copy of a *Notice of Disability* from the COBRA Plan Administrator.

Second qualifying event extension of COBRA coverage
If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse/domestic partner and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Plan Administrator. This extension may be available to the spouse/domestic partner and any dependent children receiving COBRA coverage if the employee or former employee dies; gets divorced or legally separated, or terminates a domestic partnership; or if the dependent child stops being eligible under a plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under a plan had the first qualifying event not occurred. (This extension is not available to the spouse/domestic partner and any dependent children under a plan when a covered employee becomes entitled to Medicare after electing COBRA coverage .)

This extension due to a second qualifying event is available only if you notify the COBRA Plan Administrator by completing and submitting a *Notice of Second Qualifying Event* within 60 days after the date of the second qualifying event. You can obtain a copy of a *Notice of Second Qualifying Event* from the COBRA Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Healthcare FSA Component
COBRA coverage under the Healthcare FSA will be offered to qualified beneficiaries. Healthcare FSA COBRA coverage will consist of the Healthcare FSA COBRA coverage that will be charged for the remainder of the plan year. Healthcare FSA COBRA coverage will consist of the Healthcare FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying

event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and Healthcare FSA COBRA coverage will terminate at the end of the plan year.

More Information About Individuals Who May Be Qualified Beneficiaries

- *Children born to or placed for adoption with the covered employee during COBRA coverage period*

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in a plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in a plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

- *Alternate recipients under QMCSOs*

A child of the covered employee who is receiving benefits under a plan pursuant to a qualified medical child support order (QMSCO) received by the COBRA Plan Administrator during the covered employee's period of employment with the City of Seattle is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your department's Benefits Representative informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your department's Benefits Representative or COBRA Plan Administrator.

If You Have Questions

Questions concerning your Plan or COBRA coverage should be addressed to the:

COBRA Plan Administrator
City of Seattle Personnel Department
Benefits Unit
700 5th Ave., Suite 5500
PO Box 34028
Seattle, WA 98124-4028
206-684-4659